

		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0041392</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Heritage Manor-Minonk</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/2003</u> to <u>12/31/2003</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>201 LOCUST</u> <u>Minonk</u> <u>61938</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>McLean</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Craig L. Ater</u> (Title) <u>Senior V.P. & CFO</u>	
Telephone Number: <u>(309) 432-2557</u> Fax # () _____		Paid Preparer (Signed) _____ (Date) _____ (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) _____ Fax # () _____	
IDPA ID Number: <u>370909086019</u>		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
Date of Initial License for Current Owners: <u>1995</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____		<input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____	
<input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____			
In the event there are further questions about this report, please contact: Name: <u>CRAIG L. ATER</u> Telephone Number: <u>(309) 823-7135</u>			

STATE OF ILLINOIS

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Facility Name & ID Number Heritage Manor-Minonk# 0041392 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>49</u>	Skilled (SNF)	<u>49</u>	<u>17,885</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	<u>23</u>	Sheltered Care (SC)	<u>23</u>	<u>8,395</u>	5
6		ICF/DD 16 or Less			6
7	<u>72</u>	TOTALS	<u>72</u>	<u>26,280</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>9,100</u>	<u>4,908</u>	<u>1,676</u>	<u>15,684</u>	8
9	SNF/PED			<u>0</u>		9
10	ICF					10
11	ICF/DD					11
12	SC	<u>0</u>	<u>5,991</u>	<u>0</u>	<u>5,991</u>	12
13	DD 16 OR LESS					13
14	TOTALS	<u>9,100</u>	<u>10,899</u>	<u>1,676</u>	<u>21,675</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 82.48%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 1995

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified _____ and days of care provided 1,676

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

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Facility Name & ID Number Heritage Manor-Minonk

0041392

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	A. General Services										
1	Dietary	150,019	13,748		163,767		163,767	1,858	165,625		1
2	Food Purchase		89,358		89,358		89,358		89,358		2
3	Housekeeping	62,262	8,758		71,020		71,020		71,020		3
4	Laundry	40,386	8,764		49,150		49,150		49,150		4
5	Heat and Other Utilities			70,890	70,890		70,890	824	71,714		5
6	Maintenance	41,172	19,041	15,038	75,251		75,251	8,271	83,522		6
7	Other (specify):*										7
8	TOTAL General Services	293,839	139,669	85,928	519,436		519,436	10,953	530,389		8
	B. Health Care and Programs										
9	Medical Director			612	612		612		612		9
10	Nursing and Medical Records	659,668	28,308	3,690	691,666		691,666		691,666		10
10a	Therapy		193,958	43,657	237,615	(250,805)	(13,190)	43,399	30,209		10a
11	Activities	34,153	2,909		37,062		37,062		37,062		11
12	Social Services	21,440	22,428	1,844	45,712		45,712		45,712		12
13	Nurse Aide Training	1,891	150		2,041		2,041	1,278	3,319		13
14	Program Transportation										14
15	Other (specify):*										15
16	TOTAL Health Care and Programs	717,152	247,753	49,803	1,014,708	(250,805)	763,903	44,677	808,580		16
	C. General Administration										
17	Administrative	69,699			69,699		69,699	51,253	120,952		17
18	Directors Fees							4,649	4,649		18
19	Professional Services			167,814	167,814		167,814	(159,984)	7,830		19
20	Dues, Fees, Subscriptions & Promotions			42,396	42,396	(26,828)	15,568	(5,916)	9,652		20
21	Clerical & General Office Expenses	71,791	4,619	11,571	87,981		87,981	145,108	233,089		21
22	Employee Benefits & Payroll Taxes			189,381	189,381		189,381	20,811	210,192		22
23	Inservice Training & Education			505	505		505	563	1,068		23
24	Travel and Seminar			3,915	3,915		3,915	(1,916)	1,999		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			28,020	28,020		28,020	1,435	29,455		26
27	Other (specify):*			1,000	1,000		1,000	(1,000)			27
28	TOTAL General Administration	141,490	4,619	444,602	590,711	(26,828)	563,883	55,003	618,886		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,152,481	392,041	580,333	2,124,855	(277,633)	1,847,222	110,633	1,957,855		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number

Heritage Manor-Minonk

#0041392

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			62,932	62,932		62,932	7,150	70,082			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			49,364	49,364		49,364	6,315	55,679			32
33	Real Estate Taxes			35,421	35,421		35,421		35,421			33
34	Rent-Facility & Grounds							4,778	4,778			34
35	Rent-Equipment & Vehicles			1,683	1,683		1,683	7,175	8,858			35
36	Other (specify):*											36
37	TOTAL Ownership			149,400	149,400		149,400	25,418	174,818			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					250,805	250,805		250,805			39
40	Barber and Beauty Shops		43		43		43		43			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					26,828	26,828		26,828			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		43		43	277,633	277,676		277,676			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,152,481	392,084	729,733	2,274,298		2,274,298	136,051	2,410,349			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number Heritage Manor-Minonk

0041392

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(5)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(328)	20		17
18	Fines and Penalties				18
19	Entertainment	(5,962)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,904)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,000)	27		24
25	Fund Raising, Advertising and Promotional	(8,074)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (17,273)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	153,324		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 153,324		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ 136,051		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Heritage Manor-Minonk

ID# 0041392

Report Period Beginning: 01/01/2003

Ending: 12/31/2003

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference
1	\$		1
2			2
3			3
4			4
5		0	35
6		0	34
7			7
8			8
9		0	30
10			32
11			11
12			12
13		0	2
14			32
15		0	33
16			24
17		(328)	20
18			18
19			24
20		0	27
21			21
22		(1,904)	19
23			23
24		(1,000)	27
25		(8,074)	20
26			26
27			27
28			28
29			29
30			30
31			31
32			32
33			33
34			34
35			35
36			36
37			37
38			38
39			39
40			40
41			41
42			42
43			43
44			44
45			45
46			46
47			47
48			48
49	Total	(11,306)	49

Summary A

0041392

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Summary B

Facility Name & ID Number	Heritage Manor-Minonk	#	0041392	Report Period Beginning:	01/01/2003	Ending:	12/31/2003
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Facility Name & ID Number Heritage Manor-Minonk# 0041392

Report Period Beginning:

01/01/2003

Ending:

12/31/2003

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		\$			\$	\$	1
2	V	10a Adjustment for Related Organization	60,620	GreenTree Therapy	100.00%	52,479	(8,141)	2
3	V							3
4	V	19 Adjustment for Related Organization	165,910	Heritage Enterprises, Inc.	100.00%		(165,910)	4
5	V							5
6	V	10a Adjustment for Related Organization	193,640	GreenTree Pharmacy	100.00%	245,180	51,540	6
7	V							7
8	V							8
9	V							9
10	V							10
11	V							11
12	V							12
13	V							13
14	Total		\$ 420,170			\$ 297,659	\$ * (122,511)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Minonk# 0041392Report Period Beginning: 01/01/2003Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	100.00%	\$ 1,858	\$ 1,858
16	V	2 Food Purchase				0	
17	V	3 Housekeeping				0	
18	V	4 Laundry				0	
19	V	5 Heat & Other Utilities				824	824
20	V	6 Maintenance				8,271	8,271
21	V	7 Other				0	
22	V	9 Medical Director				0	
23	V	10 Nursing & Medical Records				0	
24	V	11 Activities				0	
25	V	12 Social Service				0	
26	V	13 Nurse Aide Training				1,278	1,278
27	V	14 Program Transportation				0	
28	V	15 Other				0	
29	V	17 Administrative				51,253	51,253
30	V	18 Directors Fees				4,649	4,649
31	V	19 Professional Services				7,830	7,830
32	V	20 Fees, Subscription, Promotions				2,486	2,486
33	V	21 Clerical & General Office Expenses				145,108	145,108
34	V	22 Employee Benefits & Payroll Taxes				20,811	20,811
35	V	23 Inservice Training & Education				563	563
36	V	24 Travel and Seminar				4,046	4,046
37	V	25 Other Admin. Staff Transportation				0	
38	V	26 Insurance-Prop.Liab.Malpract				1,435	1,435
39	Total		\$			\$ 250,412	\$ * 250,412

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Minonk# 0041392Report Period Beginning: 01/01/2003Ending: 12/31/2003

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	27 Other	\$	Heritage Enterprises, Inc.	100.00%	\$ 0	\$
16	V	30 Depreciation				7,150	7,150
17	V	31 Amortization of Pre-Op & Org				0	
18	V	32 Interest				6,320	6,320
19	V	33 Real Estate Taxes				0	
20	V	34 Rent-Facility & Grounds				4,778	4,778
21	V	35 Rent-Equipment & Vehicles				7,175	7,175
22	V	36 Other				0	
23	V	38 Medically Nec Transportation				0	
24	V	39 Ancillary Service Centers				0	
25	V	40 Barber and Beauty Shops				0	
26	V	41 Coffee and Gift Shops				0	
27	V	42 Other				0	
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 25,423	\$ * 25,423

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Minonk # 0041392 Report Period Beginning: 01/01/2003 Ending: 12/31/2003

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bill Froelich	Director	Management	26.00	320,135	5	100.00	Director/Salary	\$ 9,592	line 17/18, col	1
2	Tom Jefferson	Secretary	Management	10.00	385,686	5	100.00	Director/Salary	11,556	line 17/18, col	2
3	Craig Hart	Chairman	Management	20.00	372,740	10	100.00	Director/Salary	11,168	line 17/18, col	3
4	Cheryl Lowney	Executive Vice Presi	Management	0.30	222,499	40	100.00	Director/Salary	6,667	line 17/18, col	4
5	Steve Wannemacher	President	Management	0.30	251,231	40	100.00	Director/Salary	7,528	line 17/18, col	5
6	Connie Hoselton	Sr Vice President	Management	0.20	148,865	40	100.00	Salary	4,460	line 17, col 7	6
7	Craig Ater	Sr Vice President	Management	0.20	164,565	40	100.00	Salary	4,931	line 17, col 7	7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 55,902		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Heritage Manor-Minonk# 0041392

Report Period Beginning:

01/01/2003Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1 Dietary	Beds	2,403	24	\$ 62,023	\$ 62,023	72	\$ 1,858	1
2	2 Food Purchase	Beds	2,403	24	0	0	72	0	2
3	3 Housekeeping	Beds	2,403	24	0	0	72	0	3
4	4 Laundry	Beds	2,403	24	0	0	72	0	4
5	5 Heat & Other Utilities	Beds	2,403	24	27,509	0	72	824	5
6	6 Maintenance	Beds	2,403	24	276,052	67,064	72	8,271	6
7	7 Other	Beds	2,403	24	0	0	72	0	7
8	9 Medical Director	Beds	2,403	24	0	0	72	0	8
9	10 Nursing & Medical Records	Beds	2,403	24	0	0	72	0	9
10	11 Activities	Beds	2,403	24	0	0	72	0	10
11	12 Social Service	Beds	2,403	24	0	0	72	0	11
12	13 Nurse Aide Training	Beds	2,403	24	42,658	42,572	72	1,278	12
13	14 Program Transportation	Beds	2,403	24	0	0	72	0	13
14	15 Other	Beds	2,403	24	0	0	72	0	14
15	17 Administrative	Beds	2,403	24	1,710,580	0	72	51,253	15
16	18 Directors Fees	Beds	2,403	24	155,144	0	72	4,649	16
17	19 Professional Services	Beds	2,403	24	261,316	0	72	7,830	17
18	20 Fees, Subscription, Promotions	Beds	2,403	24	82,980	0	72	2,486	18
19	21 Clerical & General Office Expense	Beds	2,403	24	4,842,980	4,501,882	72	145,108	19
20	22 Employee Benefits & Payroll Tax	Beds	2,403	24	694,554	0	72	20,811	20
21	23 Inservice Training & Education	Beds	2,403	24	18,789	0	72	563	21
22	24 Travel and Seminar	Beds	2,403	24	135,033	0	72	4,046	22
23	25 Other Admin. Staff Transportation	Beds	2,403	24	0	0	72	0	23
24	26 Insurance-Prop.Liab.Malpract	Beds	2,403	24	47,877	0	72	1,435	24
25	TOTALS				\$ 8,357,495	\$ 4,673,541		\$ 250,412	25

Facility Name & ID Number Heritage Manor-Minonk# 0041392

Report Period Beginning:

01/01/2003Ending: 2/31/2003

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27 Other	Beds	2,403	24	\$	\$	72	\$	1
2	30 Depreciation	Beds	2,403	24	238,628		72	7,150	2
3	31 Amortization of Pre-Op & Org	Beds	2,403	24			72		3
4	32 Interest	Beds	2,403	24	210,931		72	6,320	4
5	33 Real Estate Taxes	Beds	2,403	24			72		5
6	34 Rent-Facility & Grounds	Beds	2,403	24	159,466		72	4,778	6
7	35 Rent-Equipment & Vehicles	Beds	2,403	24	239,478		72	7,175	7
8	36 Other	Beds	2,403	24			72		8
9	38 Medically Nec Transportation	Beds	2,403	24			72		9
10	39 Ancillary Service Centers	Beds	2,403	24			72		10
11	40 Barber and Beauty Shops	Beds	2,403	24			72		11
12	41 Coffee and Gift Shops	Beds	2,403	24			72		12
13	42 Other	Beds	2,403	24			72		13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 848,503	\$		\$ 25,423	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	LSalle National Bank		xx	Mortgage	4640 plus Int	01/15/99	\$ 1,122,188	\$ 991,266	01/15/06	variable	\$ 34,630	1	
2	LSalle National Bank		xx	Mortgage							4,660	2	
3												3	
4												4	
5												5	
	Working Capital												
6	Central Office Allocation		xx	Working Capital							10,074	6	
7	Central Office Allocation		xx	Working Capital							6,320	7	
8												8	
9	TOTAL Facility Related						\$ 1,122,188	\$ 991,266			\$ 55,684	9	
	B. Non-Facility Related*												
10	Interest Income										(5)	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ (5)	14	
15	TOTALS (line 9+line14)						\$ 1,122,188	\$ 991,266			\$ 55,679	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

FACILITY NAME	Heritage Manor-Minonk	COUNTY	McLean
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CONTACT PERSON REGARDING THIS REPORT

TELEPHONE () FAX #: ()

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet:
 B. General Construction Type:
 Exterior
 Frame
 Number of Stories

C. Does the Operating Entity?
 (a) Own the Facility
 (b) Rent from a Related Organization.
 (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 (a) Own the Equipment
 (b) Rent equipment from a Related Organization.
 (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 YES
 NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Land			\$ 25,000	1
2					2
3	TOTALS			\$ 25,000	3

Facility Name & ID Number Heritage Manor-Minonk

0041392

Report Period Beginning:

01/01/2003

Ending: 12/31/2003

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9			
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
4	72				\$ 1,039,908	\$		\$		\$	4	
5											5	
6											6	
7											7	
8											8	
	Improvement Type**											
9	Smoke Detectors (45)		1998		3,267						9	
10	Compressor		1998		1,047						10	
11	Generator		1998		12,140						11	
12	A/C Repair		1998		1,518						12	
13	Plumbing Repair		1998		4,956						13	
14											14	
15	Water Heater		1996		2,603						15	
16	Resident Room Renovating		1996		8,483						16	
17	Exterior Painting & Renovation		1996		4,806						17	
18	Nurse Call System		1996		3,803						18	
19	Garbage Disposal		1996		867						19	
20	Boiler Repair		1996		4,436						20	
21	Receptionist Work Area Renovation		1996		1,260						21	
22	Hot Water Heater		1996		505						22	
23	Exterior Signage		1996		1,680						23	
24	Interior Rehab		1996		146,288						24	
25	Interior Rehab		1996		22,963						25	
26	Code Alert System		1996		1,319						26	
27											27	
28	Interior Rehab		1997		33,578						28	
29	Interior Rehab		1997		168						29	
30	Building Purchase Offset		1997		(141,199)						30	
31											31	
32											32	
33											33	
34	C/O Allocation							7,150	7,150		34	
35	Book Depreciation					46,614		46,614		272,204	35	
36											36	

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Door Alarm System	1999	\$ 10,116	\$		\$	\$	\$	37
38	Plumbing / Water Heater	1999	3,170						38
39	Sewage Ejector	1999	3,042						39
40									40
41	Water Heater	2000	3,293						41
42	Remove and replace patio	2000	5,890						42
43									43
44	Garbage Disposal	2001	922						44
45	Painting--Hallways/Resident rooms	2001	2,444						45
46									46
47	Water Faucet	2002	1,656						47
48	Boiler	2002	17,945						48
49	Shower Faucet	2002	2,398						49
50									50
51	Roof	2003	30,757						51
52	Faucets	2003	1,915						52
53	Compressor	2003	1,126						53
54	Disposal	2003	970						54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,240,040	\$ 46,614		\$ 53,764	\$ 7,150	\$ 272,204	70

**Improvement type must be detailed in order for the cost report to be considered complete.

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,240,040	\$ 46,614		\$ 53,764	\$ 7,150	\$ 272,204	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,240,040	\$ 46,614		\$ 53,764	\$ 7,150	\$ 272,204	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 153,337	\$ 16,318	\$ 16,318	\$		\$ 115,119	71
72	Current Year Purchases	10,152						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 163,489	\$ 16,318	\$ 16,318	\$		\$ 115,119	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 1,428,529	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 62,932	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 70,082	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 7,150	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 387,323	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☐ NO

16. Rental Amount for movable equipment: \$ 8,858 Description: pager, computer equipment

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2004 \$ _____

13. /2005 \$ _____

14. /2006 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
--	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$		\$			
2	Books and Supplies		150		150		
3	Classroom Wages (a)		1,891		1,891		
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	2,041	\$	2,041		
10	SUM OF line 9, col. 1 and 2 (e)	\$	2,041				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ _____

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$ (3,426)	\$		\$ (3,426)	1
2	Licensed Speech and Language Development Therapist		hrs			2,611			2,611	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			30,866	158		31,024	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				245,340		245,340	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					5,465			5,465	13
14	TOTAL			\$		\$ 35,516	\$ 245,498		\$ 281,014	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Page 17

Facility Name & ID Number Heritage Manor-Minonk

0041392

Report Period Beginning: 01/01/2003

Ending:

12/31/2003

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2003

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 2,490	\$	1
2	Cash-Patient Deposits	3,471		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	163,270		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,192		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,673,322		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 1,843,745	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000		13
14	Buildings, at Historical Cost	1,240,040		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	163,490		16
17	Accumulated Depreciation (book methods)	(387,323)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	9,709		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 1,050,916	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 2,894,661	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 23,016	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	3,471		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	103,765		30
31	Accrued Taxes Payable (excluding real estate taxes)	344		31
32	Accrued Real Estate Taxes(Sch.IX-B)	36,299		32
33	Accrued Interest Payable	2,792		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Escrow			36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 169,687	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	991,266		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 991,266	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,160,953	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 1,733,708	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 2,894,661	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 1,343,677	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 1,343,677	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	390,031	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 390,031	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 1,733,708	24 *

* This must agree with page 17, line 47.

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 2,580,605	1
2	Discounts and Allowances for all Levels	(360,958)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,219,647	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	103,822	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 103,822	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	907	11
12	Gift and Coffee Shop	1,592	12
13	Barber and Beauty Care	2,522	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	330,304	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	5,530	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 340,855	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	5	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 5	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 2,664,329	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	519,436	31
32	Health Care	1,014,708	32
33	General Administration	590,711	33
	B. Capital Expense		
34	Ownership	149,400	34
	C. Ancillary Expense		
35	Special Cost Centers	43	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 2,274,298	40
41	Income before Income Taxes (line 30 minus line 40)**	390,031	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 390,031	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Heritage Manor-Minonk

0041392

Report Period Beginning: 01/01/2003

Ending:

12/31/2003

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,712	1,752	\$ 39,927	\$ 22.79	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	4,893	5,293	115,854	21.89	3
4	Licensed Practical Nurses	7,511	8,135	137,639	16.92	4
5	Nurse Aides & Orderlies	34,431	37,710	354,763	9.41	5
6	Nurse Aide Trainees	300	300	1,891	6.30	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,194	1,308	11,485	8.78	8
9	Activity Director					9
10	Activity Assistants	3,763	3,964	34,153	8.62	10
11	Social Service Workers	1,133	1,346	21,440	15.93	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,160	17,656	150,019	8.50	15
16	Dishwashers					16
17	Maintenance Workers	3,354	3,782	41,172	10.89	17
18	Housekeepers	7,447	8,071	62,262	7.71	18
19	Laundry	4,169	4,381	40,386	9.22	19
20	Administrator	2,080	2,080	69,699	33.51	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,429	5,506	71,791	13.04	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	92,576	101,284	\$ 1,152,481 *	\$ 11.38	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		612		36
37	Medical Records Consultant		1,400		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,160		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		1,844		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 6,016		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses	0	\$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Nurse Aides	0	0		52
53	TOTAL (lines 50 - 52)		\$		53

XIX. SUPPORT SCHEDULES

[illegible]

* Attach copy of IMRF notifications

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

[illegible]

Facility Name & ID Number Heritage Manor-Minonk

STATE OF ILLINOIS

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Healthcare Association
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 7 Years
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 5,000 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES xx NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO No If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 26,828
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 0 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 2,901
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 100
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? Yes
Firm Name: Pellman & Dold The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. Not Complete as of this date
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.

